15.b. Intermediate care facility services (other than services in an institution for mental diseases) for persons determined, in accordance with §1902(a)(31)~~(a)~~ of the Act, to be in need of such care including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

- The same service limitations apply as specified in item 15.a.

16. Inpatient psychiatric facilities services for individuals under 22 years of age:

- The same service limitations apply as specified in Item 1, Inpatient hospital services.
- The facility must be JCAH accredited.
- Services are covered for individuals who have reached age 21, but not age 22, only if an individual was receiving such services during the period immediately preceding the individual's 21st birthday. In these cases, services may be continued up to the date an individual no longer requires services or the date the individual reaches age 22, whichever date is earlier.

17. Nurse midwife services.

Payment is limited to services provided within the scope of practice of the certified nurse midwife. In addition to traditional nurse midwife services, services within the scope of practice are:

- annual physical exams;
- prescribing the full range of birth control methods;
- administering Norplant, Depo Provera;
- diagnosing and treating sexually transmitted diseases;
- preconceptual counseling;
- evaluating breast masses and making referrals for follow-up;
- evaluating abdominal pain and making referrals for follow-up;
- evaluating women for hormone replacement therapy; and
- if administering ~~the~~ pediatric vaccines ~~listed~~ as noted in item 5.a., Physicians' services within the scope of their licensure, certified nurse midwives must enroll in the Minnesota Vaccines for Children Program.

18. Hospice care (in accordance with section 1905 (o) of the Act):

A recipient must meet each of the following conditions to receive hospice services under medical assistance:

(1) The recipient must be certified as terminally ill (i.e., the medical prognosis is that the recipient's life expectancy is six months or less, given that the terminal illness runs its normal course) within two calendar days after hospice care is initiated. A recertification statement saying the recipient is terminally ill must be obtained within two calendar days after the recipient's first 90 days of hospice care (within two calendar days after the beginning of the next 90 day period) and before each 60-day period that follows. If the hospice does not obtain written certification within two calendar days after hospice care begins, a verbal certification may be obtained within these two days and a written certification obtained no later than eight days after care begins.

(2) The recipient must live in the recipient's own home, in the community, or in a long-term care facility.

(3) The recipient must sign an election of hospice statement containing the following:

(a) the name of the hospice;
(b) an acknowledgment that the recipient understands that the hospice provides palliative, not curative care;
(c) an acknowledgment that the recipient's right to receive Medicaid payment for certain other Medicaid services (including Medicaid waivers) is being waived; and
(d) the recipient or legal representative's signature.

(4) The recipient must receive hospice care until the recipient is no longer certified as terminally ill or until the recipient or representative revokes the election of hospice.

The core services listed below must be provided directly by hospice employees. A hospice may use contracted staff, such as physicians, dentists, optometrists or chiropractors to supplement hospice employees during periods of peak patient loads or other extraordinary circumstances. The

18. Hospice care (in accordance with section 1905(o) of the Act: (continued.)

hospice remains responsible for the quality of services provided by contracted staff.

(1) Nursing services provided by or under the supervision of a registered nurse.

(2) Medical social services provided by a social worker under the direction of a physician.

(3) Counseling services provided to the terminally ill recipient and the family members or other persons caring for the recipient at the recipient's home. Counseling, including dietary counseling, may be provided to train the recipient's family or other caregiver to provide care and to help the recipient and those caring for the recipient adjust to the recipient's approaching death.

The following additional services must also be ~~provided directly by the hospice, or~~ made available by ~~it~~ the hospice:

(1) Inpatient care including procedures necessary for pain control or acute or chronic symptom management. Inpatient care is provided in a Medicare or medical assistance certified hospital, a nursing facility or an inpatient hospice unit.

(2) Inpatient care for up to five consecutive days at a time to provide respite care for the recipient's family or other persons caring for the recipient at home. Inpatient care is provided in a Medicare or medical assistance certified hospital, a nursing facility, an inpatient hospice unit, or a Medical Assistance certified intermediate care facility.

(3) Medical equipment and supplies, including drugs. Only drugs or compounded prescriptions approved by the ~~commission~~ commissioner for inclusion in the Department's Drug Formulary are covered. The drugs must be used primarily to relieve pain and control symptoms for the recipient's terminal illness. Medical appliances and durable medical equipment are included, as well as other self help and personal comfort items related to the palliation or management of the recipient's terminal illness. Medical appliances must be provided by the hospice for use in the recipient's home while the

18. Hospice care (in accordance with section 1905(o) of the Act: (continued.)

recipient is receiving hospice care. Medical supplies include those specified in the written plan of care.

(4) Home health aide services and homemaker services. Home health aides may provide personal care services. Home health aides and homemakers may perform household services to maintain a safe and sanitary environment in areas of the home used by the recipient. Examples of household services are changing the recipient's bed linens, or light cleaning and laundering essential to the comfort and cleanliness of the recipient. Home health aide services must be provided under the supervision of a registered nurse.

(5) Physical therapy, occupational therapy, and speech/language pathology services provided to maintain activities of daily living and basic functional skills.

(6) Services of a physician, dentist, optometrist, or chiropractor.

(7) Any other item or service specified in the plan of care for which payment may be made under the State plan.

There are four levels of care into which each day of hospice care is classified.

(1) Routine home care day. This is a day in which the recipient is at home and is not receiving continuous care during a crisis.

(2) Continuous home care day. This is a day in which the recipient receives predominately nursing services, and may also receive home health aide or homemaker services on a continuous basis during a period of crisis. The hospice must provide at least eight hours of care and bills using the hourly rate for the actual hours of service provided up to 24.

(3) Inpatient care day. This is a day in which the recipient received inpatient care for respite for the caregiver at home. The hospice may bill for up to five consecutive days beginning with the day of admission but excluding the day of discharge. Any respite care days beyond the five consecutive covered days must be billed

18. Hospice care (in accordance with section 1905(o) of the Act: (continued.)

as routine home care days.

(4) General inpatient day. This is a day in which the recipient receives general inpatient care in a hospital, nursing facility, or inpatient hospice unit for control of pain or management of acute or chronic symptoms that cannot be managed in the home. The hospice may bill for the date of admission, but not the date of discharge unless the recipient is discharged deceased.

Medical assistance will pay a hospice for each day a recipient is under the hospice's care. The limits and cap amounts are the same as used in the Medicare program except that the inpatient day limit on both inpatient respite care days and general inpatient care days does not apply to recipients afflicted with acquired immunodeficiency syndrome (AIDS).

No payment is made for bereavement counseling.

19. Case management services:

- Provided with limitations identified in **Supplement 1** to this Attachment for individuals who have serious and persistent mental illness or serious emotional disturbance.

- Child welfare-targeted case management provided with limitations identified in **Supplement 1A** to this Attachment for recipients under age 21 who have been assessed in accordance with Minnesota Statutes, section 256F.10 and who meet one or more of the conditions in Supplement 1A.

- Provided with limitations identified in **Supplement 1B** to this Attachment for individuals with tuberculosis.

20. Extended services to pregnant women:

- See Items 20.a. through 20.b.

20.a. **Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends**

* The following are extended services for pregnant women which vary in amount, duration, and scope from other services under this State Plan.

PRENATAL RISK ASSESSMENT: All pregnant women receiving prenatal care services funded by the State of Minnesota will be screened for risk of low birthweight/preterm birth. Factors in the assessment will include:

1) lifestyle risk, including use of alcohol and illicit or non-prescription drugs, smoking, diet, and activity;

2) medical risk;

3) genetic risk;

4) pre-term birth risk;

5) psycho-social risk, including lack of emotional supports, stress, and lack of parenting skills.

A score of 10 points or more on the MA Risk Assessment place the woman "at risk" of low birthweight/preterm birth and eligible for enhance preventive perinatal services.

Risk Assessment activities include:

1) To be eligible for MA reimbursement for the delivery of the enhanced perinatal services, a physician/certified nurse midwife shall complete a risk assessment at the recipient's first prenatal visit (and again at approximately 28 weeks gestation, optionally) on the form supplied by the Department of Human Services.

2) Physicians and certified nurse midwives must submit the completed risk assessment form to the Department of Human Services.

3) The primary provider (physician/certified nurse midwife) will receive a payment for each risk assessment form submitted to the Department (2 payments per pregnancy; limited to 4 payments per year; i.e. more than one pregnancy in a year).